STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		E & MED:ID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	STRUCTION	(X3) DATE	D. 0938-(
		ENTITION NOWBER;	A. BUILD	ING 01	- MAIN BUILDING 01	COMP	_ETED
NAME OF PROVIDER OR SU	JPPLIER	445276	B. WING			03/	28/2011
		REHABILITATION CENT	ER S	136 DAVIS			
(X4) ID SUMA PREFIX (EACH DE	MARY STATEMENT	OF DEFICIENCIES	ID	LAFOLLE	PROVIDER'S PLAN OF CORRI		
AZGOLATO	ORY OR LSC IDEN	BE PRECEDED BY FULL TIFYING INFORMATION)	PREFIX TAG	CRC	ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE AP DEFICIENCY)	ארוווי אי פר	COMPLE COMPLE
K 000 INITIAL CO	MMENTS		K 000	)			<del>i</del> -
42 CFR 483	70/->			"This I	lan of Correction is p	prepared	
K3 BUILDIN	.70(a) G: 1-story Tvr	pe V(111), unprotected,		and sul	pmitted as required by	law. By	i
11011-00111002	uble construct	IOD With a complete		submit	ling this Plan of Corre	ection.	1
- datomatic St	HIIKIEL System	i t		Cumbe	rland Village Care &		ī
K6 PLAN AF	PROVAL: 198	3 and 1094		Rehabi	litation Center does n	ot admit	;
K8 182-bed	UNDER: 200	0 EXISTING		that the	deficiency listed on t	this form	÷
K 021 NFPA 101 LI	FE SAFFTY	ODE STANDARD		exist, n	or does the Center add	mit to any	İ
20-D		1	K 021	stateme	nts, findings, facts, or	r	į.
Any door in a	in exit passage	eway, stairway		conclus	ions that form the bas	sis for the	!
T GITCIOSUIE, NO	DEIZONI'AL AVIT 6	maka harrian		alleged	deficiency. The Cent	ter	
devices arrar	ea enclosure i	s held open only by atically close all such		reserves	the right to challenge	c in legal	
40013 Dy 2011	or throughou	t the facility upon		and/or r	egulatory or administ	rative	
activation of:	0	and lading apoll		proceed	ings the deficiency,	:	
a) the require	al			stateme	nts, facts, and conclus	sions that	
a) the require				form the	basis for the deficier	icy."	
b) local smoke	e detectors de	signed to detect	1	K 021			
smoke passing through the opening or a required smoke detection system; and		İ		corridor fire door by re	. 200		
omoke detecti	on system; an	d		was repa	aired to close to a posi	oom 208	
c) the automa	tic sprinkler sv	stem, if installed.		latch on	03/28/2011 by the	itive	
19.2.2.2.6, 7.2	2.1.8.2	otom, ii installed,		Mainten	ance Director.	į,	04404
Į.			i			T.	04/18/1
			100	<ol><li>Other</li></ol>	corridor fire doors w	ere i	
1			1	reviewed	by the Maintenance	Director i	
ì			į ·	on 03/28	2011 to confirm that	they ;	
This STANDARD is not met as evidenced by:				close to a	positive latch. No re	esidents	
. Desen off obse	(Vation and inf	POVIEW the facility	j <b>'</b>	were affe	cted.		
raned to assure	one (1) of hin	e (9) corridor fire	1.	3 The N	Inintann D:		
The findings include:			3. The Maintenance Director was re-				
Observation and interview with the Maintenance			educated by the Administrator on April 12, 2011 on corridor fire doors				
Director, off Ma	rch 28 2011	at 2:00 n m	i h	eing clo	sed to a positive latch	doors	
committee the c	orridor fire doc	or by room 208		7.11E CIO	bear to a positive ratch	•	
ATORY DIRECTOR'S OR PR	OVIDER/SUPPLIE	R REPRESENTATIVE'S SIGNATU	JRE		TITLE		
100 /1	Towns.	) denotes a deficiency which the patients. (See Instructions.)	Λ	das			DATE

iny d ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DEWF21

Facility ID: TN0703

If continuation sheet Page 1 of 2

## DEPARTMENT OF HEALTH AND HI. AN SERVICES CENTERS FOR MEDICARE & MEDIC ... D SERVICES STATEMENT OF DEFICIENCIES

PRINTED: 03/29/2011 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 01 - MAIN BUILDING 01 B. WING 445276 NAME OF PROVIDER OR SUPPLIER 03/28/2011 STREET ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND VILLAGE CARE AND REHABILITATION CENTER 136 DAVIS LANE LAFOLLETTE, TN 37766 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 000 . INITIAL COMMENTS K 000 4. The Maintenance Director will 42 CFR 483.70(a) assess corridor fire doors during K3 BUILDING: 1-story Type V(111), unprotected, monthly preventative maintenance non-combustible construction with a complete automatic sprinkler system. program reviews to ensure that K6 PLAN APPROVAL: 1983 and 1984 corridor fire doors close to a positive K7 SURVEY UNDER: 2000 EXISTING latch. Results of corridor fire door K8 182-bed SNF/NF monitoring will be reviewed at our K 021 NEPA 101 LIFE SAFETY CODE STANDARD K 021 monthly Performance Improvement SS=D Any door in an exit passageway, stairway (PI) meetings. enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by The center will be in substantial devices arranged to automatically close all such compliance by 04/18/2011. doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure one (1) of nine (9) corridor fire doors were held open by approved devices. The findings include: Observation and interview with the Maintenance Director, on March 28, 2011, at 2:00 p.m. confirmed the corridor fire door by room 208 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

In deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DEWF21

Facility ID; TN0703

If continuation sheet Page 1 of 2

(X6) DATE

## DEPARTMENT OF HEALTH AND F 'AN SERVICES PRINTED: 03/29/2011 CENTERS FOR MEDICARE & MED. AID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 445276 03/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND VILLAGE CARE AND REHABILITATION CENTER 136 DAVIS LANE LAFOLLETTE, TN 37766 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PRÉFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY K 021 Continued From page 1 K 021 failed to close to a positive latch: NFPA 101 LIFE SAFETY CODE STANDARD K 025 K 025 K 025 SS=E 1. The smoke doors in the draft stop Smoke barriers are constructed to provide at least a one half hour fire resistance rating in walls in the attic above the 200 and 300 areas were closed on 03/28/2011 accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are by the Maintenance Director. protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two 2. The Maintenance Director checked separate compartments are provided on each floor. Dampers are not required in duct the smoke doors in the draft stop walls penetrations of smoke barriers in fully ducted in all attic areas to confirm they were heating, ventilating, and air conditioning systems. closed on 03/29/2011. No residents 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 were affected 3. The Maintenance Director was reeducated on maintaining smoke walls This STANDARD is not met as evidenced by: by the Administrator on April 12, Based on observation and interview, the facility 2011. The Maintenance Director will failed to assure smoke walls are maintained. be responsible for educating the The findings include: Observation and interview with the Maintenance contractors that access the attic for the Director, on March 28, 2011 at 1:00 p.m. requirement that the smoke doors in confirmed the smoke doors in the draft stop wall the attic draft stop wall must remain in the attic above the 200 and 300 areas failed to closed. remain closed. 4. The Maintenance Director will audit that smoke walls are maintained on a monthly basis. Results of audit will be reviewed at our monthly Performance Improvement (PI) meetings. Center will be in substantial

compliance by 04/18/2011.